Disability Coverage

The Citigroup Disability Plan (the "Disability Plan") provides for a Short-Term Disability (STD) and a Long-Term Disability (LTD) benefit to replace a portion or all of your earnings if you are unable to work due to an illness, injury or pregnancy.

This section describes the STD and LTD benefits available. The receipt of STD and LTD benefits is subject to the terms and conditions of the Disability Plan.

For complete details about your coverage under the LTD benefit, see the **LTD insurance certificate**, which is also part of the Disability Plan. If there is any discrepancy between the provisions in this section of the Handbook and the related insurance certificate provided by the insurance company, the provisions of the insurance certificate shall prevail.

If you incurred a disability prior to 2002 or you became a Citi employee in connection with a corporate transaction with benefits provided under another disability plan, your benefit may not be described in this Handbook. Please see the prior plan and/or related summary plan description that was applicable to when you became disabled.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the certificate at no cost to you by speaking with a Citi Benefits Center representative. Call ConnectOne at **1 (800) 881-3938.** See the *For More Information* section for detailed instructions, including TDD and international assistance.

Need to Report a Disability Leave?

To learn more about how to report a disability and what happens to your benefits coverage while you are on a leave of absence, visit www.citibenefits.com.

Definition of Years of Service for the Plan

For purposes of LTD benefits (and STD benefits initiated prior to June 1, 2024), your years of service are based on your actual time providing services to Citi as an employee. Please refer to the Citi Employee Handbook for more details about how service is calculated.

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Short-Term Disability (STD)

Having a Baby?

Explore the different programs Citi has to offer. Visit Citi For You (intranet only) or contact Health Advocate at **1 (866) 449-9933.** If you are enrolled in a Citi medical plan, additional benefits may be available. Contact your carrier for more information.

The STD benefit is a core benefit available to all benefits eligible employees. No enrollment is necessary. However, you must report all disabilities to MetLife, Citi's disability Claims Administrator, before you can receive a benefit. To report your disability, call ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance. You also can call MetLife directly at **1 (888) 830-7380.**

For a description of your responsibilities and those of MetLife when you report a disability, see the Short-Term Disability (STD) summary on citibenefits.com.

If you became disabled on or after June 1, 2024:

STD pays 100% of base salary (not benefits eligible pay) during an approved disability of up to 13 weeks. For newly hired and rehired employees (regardless of prior service), there is a 30-day waiting period before disability benefits are payable.

For more information about Paid Pregnancy Leave (PPL), Paid Parental Bonding Leave (PBL), or other leaves available under the Family and Medical Leave (FML), refer to the Citi Employee Handbook and/or Citi's FML Policy for more details on Citi For You (intranet only).

If you became disabled prior to June 1, 2024:

STD pays 100% or 60% of base salary (not benefits eligible pay) during an approved disability of up to 13 weeks based on your years of service, unless otherwise indicated. For newly hired and rehired employees (regardless of prior service), there is a 90-day waiting period before disability benefits are payable (as shown in the following schedules of benefits, unless otherwise indicated):

STD Schedule of Benefits for Benefits Eligible Employees			
Years of Service	**Weeks at 100% of Base Salary**	**Weeks at 60% of Base Salary**	**Total Weeks of Base Salary**
Less than 90 days	0	0	0
More than 90 days but less than 1 year	1	12	13
1 year but less than 2 years	4	9	13
2 years but less than 3 years	6	7	13
3 years but less than 4 years	8	5	13
4 years but less than 5 years	10	3	13
5 years or more	13	0	13

When STD Benefits Are Payable

STD benefits are payable if you incur a total disability while an "Active Employee."

You are an "Active Employee" if you:

- Are an Eligible Employee working for Citigroup doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Citigroup requires you to be; and
- Are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

- You meet the above conditions; and
- You are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

A "total disability" is defined as a serious health condition, pregnancy, injury, recovery from a procedure that results in your inability to perform the essential duties of your regular occupation for more than seven consecutive calendar days. If you remain totally disabled and are unable to work on the eighth calendar day, STD benefits — if approved — will begin on the eighth day of disability and will be paid retroactive to the first day of disability.

To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You are not considered to have a disability if your illness, injury or pregnancy prevents you from commuting to and from work only. If you are able to perform the essential duties of your job at home or elsewhere and are unable to commute to work, this limitation does not constitute a disability for benefits purposes. You cannot qualify for an STD benefit if you return to work on a part-time basis (except for statutory benefits required under applicable state law).

If you qualify for STD benefits, return to work and then within a 30-day period are unable to work as a result of the same or a related total disability, your absence will be processed as a recurrent claim. You will be eligible to receive an STD benefit for the balance of your STD period of up to 13 weeks (for a reduced period, to reflect the STD benefits paid during the prior absence) and may qualify for Long-Term Disability (LTD).

If either a recurrent disability or an unrelated disability occurs after you returned to work for more than 30 days following an initial disability, you may be eligible for an additional short-term disability benefit, not to exceed 13 weeks, if approved.

STD benefits are taxable as ordinary income. Citigroup will withhold taxes, as well as deductions for other employee benefits, from STD benefits.

STD benefits may be offset by any monies owed to Citi and/or by any state benefits, including Workers' Compensation and Social Security disability benefits. However, the Disability Plan does not subrogate STD payments.

No STD benefit is payable for claims submitted more than six months after the date of disability. However, you can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give written proof of disability during the six-month period; and
- Proof of disability satisfactory to the Claims Administrator was given as soon as was reasonably possible.

Exclusions

You will not receive STD benefits for any of the following:

- A disability when your care is not supervised by a qualified physician;
- Injuries caused by war, international armed conflict, riot or civil disobedience;
- Intentional self-inflicted injury;
- A disability that begins during an unapproved leave of absence;
- A disability that results from an attempted or committed felony, assault, battery or other public offense, or during incarceration; or
- A disability resulting from cosmetic surgery, which is a surgical procedure that is not necessary to correct a sickness or injury (except for statutory benefits required under applicable state law).

For Employees Who Work in California

If you are eligible for disability benefits, you are covered by the Citigroup California Voluntary Disability Insurance (VDI) Plan (the "VDI Plan"), unless you reject the VDI Plan. The VDI Plan replaces the state plan. For details, ask your HR representative.

If you are covered by the VDI Plan, you are not eligible to file a claim with the state. You must report your disability to MetLife. Call ConnectOne at **1 (800) 881-3938.** See the *For More Information* section for detailed instructions, including TDD and international assistance. You also can call MetLife directly at **1 (888) 830-7380.**

Long-Term Disability (LTD)

LTD benefits are provided through a MetLife group disability policy in the event you suffer a covered disability. You may be eligible to receive LTD benefits if your approved Short-Term Disability (STD) claim was paid for 13 weeks. LTD coverage is offered to replace 60% of your benefits eligible pay (predisability earnings) determined on the day before your approved STD. Your "predisability earnings" under the MetLife disability insurance certificate constitutes your benefits eligible pay (as defined by the Disability Plan) for purposes of the LTD benefit.

For purposes of calculating your LTD benefit, benefits eligible pay is limited to a maximum of $500,000. In no event shall the monthly benefit exceed $25,000 per month.

Disability benefits received from any state disability plan, Social Security and the LTD portion of the Disability Plan, combined, will not exceed 60% of your benefits eligible pay.

Participation

Citi provides Company-paid LTD coverage to employees whose benefits eligible pay is less than or equal to $50,000.99. If your benefits eligible pay is less than or equal to $50,000.99, you do not need to enroll for coverage and there is no cost to you.

If, as a new hire, your benefits eligible pay exceeds $50,000.99, you will be automatically enrolled in LTD coverage with an option to decline coverage.

If your benefits eligible pay increases to $50,001 or above for benefits purposes for Annual Enrollment in the next plan year, you will be automatically enrolled in LTD coverage so your coverage continues uninterrupted. The cost of LTD coverage will be deducted from your pay beginning January 1 of the next plan year (following Annual Enrollment) unless you decline coverage. Refer to the Your Benefits Resources™ website, available through My Total Compensation and Benefits at **www.totalcomponline.com,** during Annual Enrollment for the cost.

Option to Decline LTD Coverage

If you do not elect "no coverage" during Annual Enrollment when your benefits eligible pay exceeds $50,000.99 for the next plan year (or as a new hire with the requisite benefits eligible pay), you will be automatically enrolled in LTD coverage. If you elect to decline LTD coverage within the first 90 days following your enrollment, you will receive a refund of your paid premiums. You can also decline LTD coverage after the initial 90-day period; however, premiums will not be refunded to you.

Note: If you decline LTD coverage and then decide to enroll in LTD coverage at any time, other than when first eligible or as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health before coverage will be approved.

If Your Benefits Eligible Pay Is:	
$50,000.99[1] or less	Citi provides LTD coverage at no cost to you.
From $50,001 to $500,000	You will pay for coverage with after-tax dollars. The LTD benefit under the Citi plan is tax-free, meaning you do not pay taxes on the benefit you receive from MetLife.

[1] If your benefits eligible pay increases to above $50,000.99 for benefits purposes for the following plan year, you will be automatically enrolled in LTD coverage, during Annual Enrollment, for the following year (new hire enrollment commences with employment). Effective January 1 of the following year, contributions will be deducted from your pay (new hire deductions occur upon employment). If you do not want LTD coverage, you must select "no coverage" during Annual Enrollment. However, if you do not opt out of LTD coverage during Annual Enrollment, you will have 90 days to opt out. If you opt out within this 90-day period, these contributions will be refunded to you. You can also opt out after the 90-day period; however, premiums will not be refunded.

Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins). See the following schedule:

LTD Benefits	
Age When Total Disability Begins (when STD becomes effective)	**Date Monthly LTD Benefits Will Stop**
Under 60	Upon attaining age 65
60	The date the 60th monthly benefit is payable
61	The date the 48th monthly benefit is payable
62	The date the 42nd monthly benefit is payable
63	The date the 36th monthly benefit is payable
64	The date the 30th monthly benefit is payable
65	The date the 24th monthly benefit is payable
66	The date the 21st monthly benefit is payable
67	The date the 18th monthly benefit is payable
68	The date the 15th monthly benefit is payable
69 or over	The date the 12th monthly benefit is payable

You will be billed for your health and insurance benefits to the extent you are enrolled. The cost of benefits is not deducted from your LTD benefit. For more details about your benefits and eligibility while on a continued LTD leave, see the *Eligibility and Participation* section.

Unless you have other disability coverage, you should consider enrolling in LTD since LTD coverage protects you in the event your ability to work is impaired by an accident or illness.

Pre-existing Condition

The LTD portion of the Disability Plan will not cover any disability caused by or contributed to, or resulting from, a pre-existing condition until you have been enrolled in the Disability Plan for 12 consecutive months.

A pre-existing condition is an injury, sickness or pregnancy for which, in the three months before the effective date of coverage, you received medical treatment, consultation, care or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care or treatment.

Converting Your Coverage

If you have been enrolled in the Disability Plan for at least one year and leave Citi (other than to retire), you can convert your Citi LTD coverage under the group policy to an individual policy within 31 days after your employment ends.

The maximum benefit of this individual policy is $3,000 per month. To obtain conversion information, call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938.** See the *For More Information* section for detailed instructions, including TDD and international assistance.

When LTD Benefits Are Payable

If you are enrolled in LTD coverage (pursuant to the terms of the Disability Plan on your date of hire) and have received 13 weeks of STD benefit payments, you may be eligible for a LTD benefit.

For purposes of initially qualifying for a LTD benefit, a disability means that due to sickness, pregnancy or accidental injury you are receiving appropriate care and treatment from an attending physician on a continuing basis and are unable to perform your own occupation for any employer in your local economy. Refer to the insurance certificate for additional details.

If you have consecutive, concurrent or continuous disabilities, related or unrelated, which continue for a period of more than 13 weeks and, if eligible and approved, you will receive an LTD benefit from MetLife. If you are approved for Social Security Disability Insurance (SSDI) for yourself and/or your dependents, your monthly LTD benefit will be offset by SSDI, dependent SSDI and any state disability benefits you may receive. The state and Social Security benefits may be subject to tax.

Your LTD benefit will not be offset for any SSDI cost-of-living adjustments. If you are approved for SSDI retroactively and receive a lump-sum SSDI award, you are required to submit any overpayment of benefits to MetLife. Any other income you receive while you are receiving LTD benefits may be used to offset your LTD benefit as described in the LTD insurance certificate at the Citi Benefits Handbook site. This is not applicable to Individual Disability Insurance Plans (IDIs).

While on an LTD leave, MetLife will send you instructions on how to apply for SSDI benefits, tax information and relevant forms, and may request ongoing medical and financial information be provided to certify your continued disability under the Disability Plan.

Claims and Appeals

You should file a STD claim as soon as you know you will be out of work for more than seven consecutive calendar days due to a non-work-related illness. If you are unable to file the claim yourself, someone may file the claim on your behalf.

To file a claim, call MetLife, the Claims Administrator for STD benefits, at **1 (888) 830-7380;** for text telephone service, call **1 (877) 503-0327.** You can also call ConnectOne at **1 (800) 881-3938** and follow the prompts to report a disability. See the *For More Information* section for detailed instructions, including TDD and international assistance.

You should expect to provide the Claims Administrator with the following information when you call:

- Name, address, telephone number and GEID;
- Manager's/supervisor's name, telephone number, email address and mailing address;
- Your health care provider's name, address and telephone number; and
- Information about your illness. **Note:** You should not give specifics, such as a medical diagnosis, for non-work-related injuries or illnesses to your manager/supervisor.

After you report a claim, the Claims Administrator will contact you if any additional information is necessary for MetLife to evaluate your claim. Once the Claims Administrator has collected and reviewed all the relevant data, the Claims Administrator will approve or deny your claim. Benefits are approved for a fixed period of time, as determined by the Claims Administrator. The initial approval period is an estimate of how long it would take a regular person to recover from your disabling condition and may be adjusted based on medical information or other extenuating circumstances.

The case manager assigned to the claim will notify both you and your manager of the Claims Administrator's decision regarding your claim. The Claims Administrator will specify a date that you are expected to return to work from an approved claim. If you are unable to return to work on the specified date, contact the Claims Administrator immediately.

MetLife, as the fiduciary, is responsible for adjudicating claims for benefits under the Disability Plan and for deciding any appeals of denied claims. The Claims Administrator shall have the authority, in its discretion, to interpret the terms of the Disability Plan, to decide questions of eligibility for coverage or benefits under the Disability Plan, and to make any related findings of fact. All decisions made by the Claims Administrator shall be final and binding on participants and beneficiaries to the fullest extent permitted by law.

Except as otherwise prescribed by the rules of the Plan Administrator or Claims Administrator, the procedures will be as described in "Initial Determination" on page 8 and "Appealing the Initial Determination" on page 8.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issued guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency, which ended on May 11, 2023.The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency

If your deadline to file a claim or appeal occurred during the National Emergency (March 1, 2020 - May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your claim or appeal.

For more information, call MetLife, the Claims Administrator for STD benefits, at **1 (888) 830-7380;** for text telephone service, call **1 (877) 503-0327.** You can also call ConnectOne at **1 (800) 881-3938** and follow the prompts to report a disability. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Disability Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45-day period (or prior to the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision; and
- An explanation why you are appealing the initial determination.

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based, and notifying you of your right to bring an action under Section 502(a) of ERISA in connection with this determination. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.